

**Orthopedic & Sports Medicine Specialists of Green Bay**  
(Orthopedic Associates of Green Bay Division)  
2223 Lime Kiln Rd Suite 1 Green Bay, Wisconsin 54311  
(920) 468-0246 Fax: (920) 569-5933

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS INFORMATION**  
**PLEASE FILL OUT COMPLETELY**

**Patient Name:** \_\_\_\_\_  
**D.O.B.** \_\_\_\_\_

**The individual or organization that is releasing the medical information:**

Name: \_\_\_\_\_  
Street: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**The individual or organization that is receiving the medical information:**

Name: **ORTHOPEDIC & SPORTS MEDICINE SPECIALISTS OF GREEN BAY**  
Street: **2223 LIME KILN ROAD SUITE 1**  
City: **GREEN BAY** State: **WI** Zip Code: **54311**

**TYPE OF INFORMATION TO BE RELEASED:** \_\_\_\_\_

X-ray CD: \_\_\_\_\_ Yes \_\_\_\_\_ No

**Purpose for release of medical records:** \_\_\_\_\_

**Effective Date of Release:** \_\_\_\_\_ **Effective Date of Termination** \_\_\_\_\_

Right to inspect or copy the information disclosed: I understand that I have a right to inspect or copy the information used or disclosed. I may contact Orthopedic & Sports Medicine of Green Bay's Privacy Officer.

I AUTHORIZE THE USE OR DISCLOSURE OF THE ABOVE NAMED INDIVIDUALS HEALTH INFORMATION AS DESCRIBED ABOVE. I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION.

**PATIENT NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_